DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Distribution: X and Z

POLICY GUIDE 2003.06

SPECIALIZED FOSTER CARE

DATE: April 11, 2003

TO: Rules and Procedures Bookholders

FROM: Jess McDonald

EFFECTIVE DATE: Immediately

I. PURPOSE

This Policy Guide replaces Policy Guide 2002.07. The instructions for accessing specialized foster care for cases stepping down from institutions and group homes have been removed from this Policy Guide. A separate Policy Guide will be issued for those cases.

The purpose of this Policy Guide is to provide instructions to staff on the **CFS 418-J, Checklist for Children at Initial Placement,** and the process for specialized foster care and to provide answers to frequently asked questions.

II. PRIMARY USERS

The primary users of this Policy Guide are all DCFS and POS staff responsible for making the decision for placement of children.

III. CHECKLIST FOR CHILDREN AT INITIAL PLACEMENT

Effective immediately, the attached **CFS 418-J, Checklist for Children at Initial Placement**, must be completed and submitted to the regional assignment unit (CAPU for Cook County, APT for Downstate Regions) for all children entering substitute care, even if the child was previously placed in substitute care.

If ANY of the items other than 'none' are selected on the **CFS 418-J**, the worker making the decision to place a child should fax this form and supporting documentation, as indicated in Section IV B that follows, to the DCFS Specialized Foster Care Gatekeeper at 312-814-1905 (fax).

There will be instances in which the child's special needs will not be known and/or documented at the time of initial assignment. If any of the conditions included on the Checklist (**CFS 418-J**) become known and documented within the first ten days after assignment via rotation, the child's case should be referred to the DCFS Specialized Gatekeeper for an Expedited Review in accordance with the process in Section IV B, of

this Policy Guide.

Children with special needs identified more than ten days after assignment should access System of Care (SOC) services to support the child in placement. A child that is severely compromised where his/her functioning in all domains (foster home, school, community) are significantly impaired, may be considered for a DCFS Specialized Gatekeeper Scheduled Review only after SOC services have been accessed.

IV. NEW PROCESS FOR SPECIALIZED FOSTER CARE

A. Eligible Children

The following categories of children are appropriate to refer to the DCFS Specialized Foster Care Gatekeeper for review:

- children in initial placement where the child has severe, chronic conditions that require a highly structured program; and
- children in a licensed foster care placement that have gone through System of Care (SOC) services and due to the severe, chronic nature of their disability, SOC is recommending that the child be placed in a specialized foster care program.

B. Process to Request a Review for Specialized Foster Care

1. In order for a review to occur, a packet must be completed for each child and faxed to the DCFS Specialized Foster Care Gatekeeper at 312-814-1905 or mailed to:

   DCFS Specialized Foster Care Gatekeeper
   100 W. Randolph, Suite 6-100
   Chicago, IL 60601

2. The packet must include the following information:

   - **CFS 418-J, Checklist for Children at Initial Placement (applicable only for children new to the system)**
   - **CFS 418-K, Specialized Foster Care Review Committee Coversheet**
   - A summary of the child's needs, including diagnosis, statement as to why a more intensive setting is needed, what services are (or have been) put in place, and what additional services the child needs;
   - The child's substitute care placement history;
   - If the child was recently referred to SOC, state the services that were requested and the outcome. Also submit a copy of the child's plan developed through SOC;
   - **CFS 418-F, Certification of Mental Health/Behavioral Special Needs** and/or **CFS 418-E, Certification of Medical/Physical Special Needs** (original copies);

- **Recent** supporting documentation that describes the child's identified needs; and
- Current social history.

The supervisor must sign the **CFS 418-K** verifying that the information is accurate.

C. Review by the Specialized Foster Care Gatekeeper

1. Decisions made by the Department will be sent in writing to the caseworker. Outcomes of the Gatekeeper's review may entail: request for additional assessment; specific services that should be accessed; referral to SOC for case coordination; or determination of whether a child should be referred to a specialized foster care program. In certain situations the Gatekeeper may request a staffing (in-person or by phone) to discuss the needs of the child.

2. Children who are determined appropriate for specialized foster care must be referred to a private agency that has a program that matches the child's identified special needs. The gatekeeper will assist in this matching. The child's case will be transferred to the specialized foster care private agency. The foster parent can choose to remain licensed with DCFS or another agency or transfer their license to the specialized foster care agency.

3. If a child is authorized to enter a specialized foster care program and the case management agency is different from the licensing agency, the board rate will be set in accordance with the rate provided by the case management agency.

D. Placement Steps after Authorization is Received

1. After approval by the DCFS gatekeeper, the worker will need to contact the placement clearance desk (PCD) to receive authorization to place a child with a specific licensed provider in accordance with Procedures 301, Appendix E. The PCD staff will verify via CM-18 that approval for a specialized foster care placement has been given and will issue a clearance number to the worker unless there are other issues that prohibit placement with the provider.

2. The worker must complete a **CFS 906, Placement/Payment Authorization Form,** and call the **CFS 906** into the appropriate business unit.

3. If PCD does not approve the placement, the worker must contact the Gatekeeper at 312-814-6880 for consideration of another identified foster home or to seek placement with another specialized foster care program.

4. If the agency providing ongoing case management changes due to approved entry into a specialized foster care program, the worker must submit a completed **CFS 1425, Change of Status** form to the regional agency performance team (APT). If the case is an initial placement then the worker is responsible for all of the regular case opening processes specified in administrative procedures.

V. FREQUENTLY ASKED QUESTIONS

1. **If the level of care (LOC) was completed prior to 5/2/02 on an unlicensed relative caregiver, and a specialized special service fee was approved, will that fee continue?**

   Yes, the caregiver should continue to receive the specialized special service fee as long as the child remains placed in the same home. The Specialized Foster Care Gatekeeper will need to review the case if the child moves to a new placement.

2. **If a LOC was completed prior to 5/2/02 and the child is later placed out of the home for 30 days or less (e.g. hospitalization, being on run, or detention) and then returned to the same caregiver, will the board rate still be grandfathered in at the existing rate?**

   As long as the placement outside of the caregiver's home is 30 days or less and the child returns to the same home, the board rate will remain at the same level and the case will not have to be reviewed through the DCFS Specialized Foster Care Gatekeeper.

3. **Does the administrative rate for cases in specialized foster care prior to 5/2/02 remain the same?**

   The administrative rate paid to a POS agency will be subject to reviews in the future. If the child no longer requires the services offered in a specialized foster care program, the administrative rate may be decreased to the HMR/Traditional amount. If one of these children moves into a new foster home after 5/2/02, the DCFS Specialized Foster Care Gatekeeper must be notified.

4. **Will a child who was in specialized foster care prior to 5/2/02 always be entitled to the same board rate?**

   These children will remain at the same board rate as long as the child remains in the same foster home. The Specialized Foster Care Gatekeeper will need to review the case if the child moves to a new placement.

5. **Will agencies continue to be responsible for completing the scheduled reviews as stated on the tickler reports for children in specialized foster care?**

The tickler reports will no longer be distributed. Until agencies receive further notice, they will not be responsible for completing reviews on children currently in specialized foster care. Notice will be sent out to all specialized foster care providers of any reviews that may take place in the future.

6. **If a child did not qualify for specialized foster care and a re-review/appeal was requested prior to 5/2/02 will it still occur?**

Yes, a re-review/appeal will take place as laid out in Policy Guide 2001.03 as long as the LOC was submitted prior to 5/2 /02 and the request for the re-review appeal is submitted within 60 calendar days of the LOC effective date of the original LOC review.

7. **If a worker or foster parent wants to request a re-review on a case that was originally reviewed prior to 5/2/02, to whom should the request be sent?**

The request for a re-review should be sent to the LOC Reviewer in the region where the original LOC review was completed as long as the re-review is requested within 60 calendar days of the LOC effective date of the original LOC review.

8. **If the LOC expired, and the agency's rate was reduced what, if any, impact does this have on the foster parent board rate?**

The board rate to the caregiver in these situations remains the same. A specialized special service fee is issued to the private agency for the foster parent. Agencies are responsible for passing on this specialized special service fee to the foster parents. Likewise, the board rate for children in DCFS homes with expired LOC reviews will not be impacted.

9. **If a child on my caseload is placed out of state, but I would like to request a specialized foster care program, increased service provisions or some equivalent, what is available and how should I proceed?**

Workers can request a specialized special service fee for children in out of state placements with needs greater than a typical relative or traditional placement from the DCFS Specialized Foster Care Gatekeeper. If approved, the Gatekeeper will send the approval to the central office unit for entry of payment.

10. **If the LOC expired prior to 5/2/02 and the child is going into an adoption or guardianship arrangement where financial assistance will be issued on behalf of an eligible child, what will the subsidy rate be?**

The adoption assistance or subsidized guardianship subsidy should reflect the negotiated amount not to exceed the current board rate plus the specialized special service fee that was put in place to hold the board rate at

the same level. POS adoption liaisons will use the subsidy verification process to confirm the proposed subsidies. DCFS subsidies will go through the standard approval process.

12. **Can a subsidy be increased if a LOC review was not submitted to DCFS prior to 5/2/02?**

Only in situations where the DCFS Gatekeeper has approved a child to enter a specialized foster care program.

13. **Will any of the changes in specialized foster care impact performance contracts?**

Cases that were stepped down to HMR/Traditional foster care prior to 5/2/02 have been counted as new intake for relative or traditional contracts and will be factored into any outcome measures.

Children with an expired LOC who achieve permanency will count as a specialized positive outcome if the outcome occurred within the last 90-days of the change in specialized status. Otherwise, the case will be counted as HMR or Traditional positive outcome.

VI. QUESTIONS

Questions about this Policy Guide or other specialized foster care issues may be directed to Alexis Oberdorfer at 312/814-6870.

VII. ATTACHMENTS

CFS 418-E, Certification of Medical/Physical Special Needs
CFS 418-F, Certification of Mental Health/Behavioral Special Needs
CFS 418-J, Checklist for Children at Initial Placement
CFS 418-K, Specialized Foster Care Review Committee Coversheet

These forms can be ordered in the usual manner. They are also available as templates on the T-Drive and on the DCFS Web page.

VIII. FILING INSTRUCTIONS

Remove Policy Guide 2002.07 in Procedures Section 301.60, Placement Selection Criteria and replace with this Policy Guide.

CFS 418-E – (MD)
Rev. 07/2002

ILLINOIS DEPARMENT OF CHILDREN AND FAMILY SERVICES

Certification of Medical/Physical Special Needs

Child's Name: _____ **Date of Birth:** _____/_____/_____

Caseworker's Name: _____

Child's Case ID: _____

Date of Child's Last Physical Exam: _____

INSTRUCTIONS FOR CASEWORKER:
An M.D. must complete this form for all children with medical/physical special needs requesting a review for entry into a Specialized Foster Care Program.

INSTRUCTIONS FOR M.D. COMPLETING THIS FORM:
The purpose of this form is to provide health and medical information to be used to make placement decisions. **Please complete this entire form and send to the child's caseworker at the following address:**

_____

_____

1. **Chronic health problems or physical conditions requiring regular medical care or interventions. Specify *diagnoses* and *severity*. PLEASE PRINT:**

_____

_____

_____

2. **Treatments/ Procedures required. Check off all treatment/procedures that the child requires and state the frequency when asked:**

- ☐ Nasal and/or oral suctioning.
- ☐ Tracheal suctioning.
- ☐ Chest physiotherapy with suctioning.
  ___ Times per day
- ☐ Cardiac monitoring.
- ☐ Apnea monitoring.
- ☐ Nebulizer treatments.
  ___ Times per day
- ☐ Cerebral shunt monitoring.
- ☐ Oxygen therapy.
  - ☐ *Continuous.*
  - ☐ *Intermittent.*
- ☐ Oxygen saturation monitoring.
- ☐ Tracheostomy care.
- ☐ Ventilator dependent care.
  - ☐ *Continuous.*
  - ☐ *Intermittent.*
- ☐ Universal precautions required to prevent child and/or caregiver infection.
- ☐ Hourly/daily monitoring of vital signs.
- ☐ Feeding tubes; *specify type.* _____
- ☐ Special nutritional needs; *specify formula* or diet:
  _____
- ☐ Encropretic; *specify frequency.*_____
- ☐ Enuretic; *specify frequency.*_____
- ☐ Other ostomies: type _____
- ☐ Daily injections.
  - ☐ *Self-administered.*
  - ☐ *Caregiver administered.*
- ☐ Glucose monitoring.
- ☐ Urinary catheters care.
  - ☐ *Independent.*
  - ☐ *Caregiver assistance required.*
- ☐ Urine checks.
- ☐ Total assistance requiring constant use and care of in-dwelling equipment.
- ☐ Central catheter care.
- ☐ Daily/frequent sterile dressing changes (burns, large wounds, bedsores).
- ☐ Daily/frequent clean dressing changes (burns, large wounds, bedsores).
- ☐ Monitor change in health status.
- ☐ Infant stimulation procedures.
- ☐ Precautions due to severe allergies.
- ☐ Surgical interventions expected; *specify.*
  _____
  _____
- ☐ Special needs resulting from surgery; *specify.*
  _____
  _____

☐ Monitoring/ interventions due to a high risk pregnancy; *specify risks and interventions/ monitoring:* _____	☐ TECHNICAL OR ADAPTIVE DEVICES: ☐ Hearing Aid ☐ Wheelchair ☐ Walker ☐ Orthopedic braces; *specify:* _____ ☐ Other; please describe: _____
☐ Physical therapy; *specify frequency*. _____	☐ MEDICATIONS: List medications; *specify medication route and frequency*. _____
☐ Occupational therapy; *specify frequency*. _____	
☐ Speech therapy; *specify frequency*. _____	
☐ Environmental adaptations required; *describe*. _____	

3. **Durable (non-disposable) Medical Equipment that child needs in the home.** For example, apnea monitor, feeding pump, suction machine:

_____

_____

_____

_____

4. **Other Care.** List any other treatment or procedures the child is receiving that have not already been stated on this form. Specify treatment required, how often it is required, and who provides this treatment:

_____

_____

_____

_____

_____

_____

5. Child's current weight: _____

Signature of Person Completing Form: _____

Printed Name: _____

☐ **MD** **License Number:** _____

Date: _____/_____/_____

Name of Hospital/Clinic: _____

Telephone number: _____

ILLINOIS DEPARTMENT OF CHILDRE AND FAMILY SERVICES

Certification of Mental Health/Behavioral Special Needs

Child's Name: _____ **Date of Birth:** _____/_____/_____

Name of clinician completing this form: _____ **Phone:** _____

Clinician's agency: _____

How long has clinician known this child? _____

INSTRUCTIONS FOR CASEWORKERS AND CLINICIANS:

1. This form must be completed and submitted on all children with mental health/behavioral special needs who are age six and older. **Incomplete forms will not be evaluated.**
2. This form must be completed by a licensed clinical social worker, psychologist, professional counselor, or psychiatrist after completing an in-person clinical interview with the child and, if possible, the child's caregiver.
3. Provide all diagnostic information specified below, using **DSM-IV-TR** criteria as the basis for all Axis I and II diagnoses made. Provide **complete** DSM-IV-TR codes and **specify severity** and all other relevant information for all disorders diagnosed. For example, **do not** write "296, Major Depressive Disorder"; instead, write "296.22, Major Depressive Disorder, single episode, moderate severity."
4. **Do not make any diagnoses unless all criteria for the diagnosis are currently met**, including symptoms and any functional impairment specified by the DSM-IV-TR. For disorders previously diagnosed but currently not meeting the full criteria for diagnosis, specify "past history" or "in full remission."
5. If you have been requested to make an assessment of the child's level of risk for suicide, self injury, serious harm to others, fire setting, or sexual aggression toward others, attach your report(s) of risk assessment. If, during your interview with the child or the child's current caregiver, you become concerned that the child is **currently** at risk for the behaviors listed above, these concerns should be documented in the risk section.

THIS FORM DOES NOT TAKE THE PLACE OF IMMEDIATE INTERVENTION THAT IS NEEDED.

AXIS I: Clinical Disorders/Other Conditions That May Be a Focus of Clinical Attention

Diagnostic code	DSM-IV-TR diagnosis, with current severity (if applicable)
___ ___ ___.___ ___	_____
___ ___ ___.___ ___	_____
___ ___ ___.___ ___	_____

ALSO REQUIRED: List all symptoms that cause clinically significant distress or impairment in the child's social, academic, or other important areas of functioning. (See **attached List of Symptoms** for relevant symptoms). Specify severity and frequency of significant symptoms. Include symptoms of chemical dependency and behavior problems.

_____

_____

_____

_____

AXIS II: Personality Disorders

Diagnostic code	DSM-IV-TR name
___ ___ ___.___ ___	_____

AXIS V: Children's Global Assessment of Functioning Scale

Before completing Axis V, please refer to the **attached Children's Global Assessment Scale**. This scale has anchored descriptions of levels of children's functioning. Choose the number that best corresponds to the child's overall level of functioning **in the past 28 days.** **SCORE:** _____

ROLE IMPAIRMENT: For each area listed below, specify the child's level of impairment. **First, write "none," "minimal," "mild," "moderate," or "severe."** Then describe functioning in the setting in specific terms. E.g., specify how often the child does not attend school, gets into fights, etc. Attach additional sheets if needed.

Area **Level of Role Impairment** (You must specify "none," "minimal," "mild," etc.)

Foster home _____

_____

School _____

_____

Community _____

_____

Other: _____

(Describe) _____

Descriptions of Levels of Role Impairment

NONE OR MINIMAL: Generally meets expectations. May have minor problems in the setting which can be adequately resolved. **MILD**: Frequently does not meet reasonable expectations due to depressed mood or behavior problems, but will comply if caregiver or teacher insists or provides increased structure. In school, performs consistently lower than expected or occasionally breaks rules, but does not harm others or property. Or, has had a single incident in the setting in recent months such as vandalism, shoplifting, a physical fight, etc. **MODERATE:** Persistently fails to comply with reasonable rules or expectations in the setting due to depressed mood, behavior problems, or lack of awareness of surroundings. Increased structure and prompting often does not lead to compliance. In home, also include running away overnight when whereabouts are known (e.g., to relative's or friend's house). In school, also include failing at least half of classes (not due to mental retardation or learning disabilities) or often truant or absent (at least 1 time every 2 weeks, or often several days together). Or, has had more than one serious incident in the setting in recent months such as vandalism, shoplifting, self injury, physical fighting, etc. **SEVERE:** serious and repeated violations of rules or expectations due to depressed mood, behavior problems, or lack of awareness of surroundings which require constant management by caregiver or teacher. In home, also include running away overnight when whereabouts are unknown (occurred in past 3 months). In school, also include dropped out and holds no job, failing all or most of classes (not due to mental retardation or learning disabilities) or expelled from school. Or, has had several serious incidents in the setting in recent months such as vandalism, shoplifting, self injury, physical fighting, etc.

Risk Assessment:

Check the category that best describes the child's **current** level of risk for each item listed below:

1. Suicide risk:	☐ Very little/No risk	☐ Moderate risk	☐ High risk
2. Self-injury risk:	☐ Very little/No risk	☐ Moderate risk	☐ High risk
3. Fire-setting risk:	☐ Very little/No risk	☐ Moderate risk	☐ High risk
4. Harm to others:	☐ Very little/No risk	☐ Moderate risk	☐ High risk
5. Sexual aggression toward others:	☐ Very little/No risk	☐ Moderate risk	☐ High risk

If any risk has been indicated, describe the level of supervision and the interventions that you recommend to assure the child's and other's safety in **an attached report**.

By signing below I certify that to the best of my knowledge, all of the information I have provided concerning this child's mental health is correct and accurately reflects his or her mental health needs at this time.

Signature of Clinician: _____ **License #:** _____

Signature of Clinician's Supervisor (if needed): _____

Date of Assessment: _____/_____/_____

Children's Global Assessment Scale

(For Children 3 to 18 Years of Age)

Rate the subjects most impaired level of general functioning for the specified time period by selecting the *lowest* level which describes his/ her functioning on a hypothetical continuum of health-illness. Use intermediary levels when most appropriate (e.g., 35, 58, 62).

Rate actual functioning regardless of treatment or prognosis. The examples of behavior provided are only illustrative and are not required for a particular rating.

Specified Time Period: Past 28 days

100-91 ***Superior functioning*** in all areas (at home, at school, and with peers); involved in a wide range of activities and has many interests (e.g., has hobbies or participates in extracurricular activities or belongs to an organized group such as scouts, etc); likeable, confident; Everyday worries never get out of hand; doing well in school; no symptoms.

90-81 ***Good functioning in all areas;*** secure in family, school, and with peers; there may be transient difficulties and Everyday worries that occasionally get out of hand (e.g., mild anxiety associated with an important exam, occasionally `blows up` with siblings, parents, or peers).

80-71 ***No more than slight impairment in functioning*** at home, at school, or with peers; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separations, deaths, birth of a sibling), but these are brief and interference with functioning is transient; such children are minimally disturbing to others and are not considered deviant by those who know them.

70-61 ***Some difficulty in single area but generally functioning pretty well*** (e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her might well express concern.

60-51 ***Variable functioning with sporadic difficulties or symptoms in several but not all social areas;*** disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.

50-41 ***Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area,*** such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.

40-31 ***Major impairment in functioning in several areas and unable to function in one of these areas,*** i.e., disturbed at home, at school, with peers, or in society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behavior due to either mood or thought disturbance, suicide attempts with clear lethal intent; such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not sufficient criterion for inclusion in this category).

30-21 ***Unable to function in almost all areas,*** e.g., stays at home, in ward, or in bed all day without taking part in social activities *or* severe impairment in reality testing *or* serious impairment in communication (e.g., sometimes incoherent or inappropriate).

20-11 ***Needs considerable supervision*** to prevent hurting others or self (e.g., frequently violent, repeated suicide attempts) *or* to maintain personal hygiene *or* gross impairment in all forms of communication, e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.

10-1 ***Needs constant supervision*** (24-hr care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect, or personal hygiene

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CFS 418-J
7/2002

State of Illinois
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
CHECKLIST FOR CHILDREN AT INITIAL PLACEMENT

Directions:

Effective immediately the CFS 418-J, Checklist for Children at Initial Placement, must be completed and submitted to the regional assignment unit (CAPU for Cook County, APT for Downstate Regions) for all children entering substitute care even if the child was previously placed in substitute care. The checklist must be included in the case opening packet at the time of case assignment. The checklist is child specific. All of the items that appropriately describe the child's special needs should be checked. The option 'none' should only be checked if the child does not have any of the special needs listed below. **If ANY of the items other than 'none' are selected, the worker making the decision to place a child should fax this form and supporting documentation to 312-814-1905 Attention: DCFS Specialized Gatekeeper. This form should also be placed in the child's file. Please note this form should only be faxed to the DCFS Specialized Gatekeeper if one of the items other than 'none' is checked below.**

If the child is approved by the DCFS Gatekeeper for Specialized Foster Care, he/she will be eligible to be placed directly in a specialized program and the gatekeeper will assist in locating an appropriate agency to meet the child's needs. Any questions regarding this checklist should be made to the DCFS Specialized Gatekeeper at 312-814-6880.

Child's Last Name:_____ Child's First Name:_____

SCR #:_____ Child's ID #:_____

CHECK ALL OF THE APPROPRIATE ITEMS BELOW:

___ None of the below conditions

___ Child is currently in a psychiatric hospital or has been psychiatrically hospitalized within 72 hours of day of intake

___ Child is an alleged sexual perpetrator confirmed by a delinquency petition and/or an indicated SCR report

___ Child has a diagnosed severe and chronic mental illness that impairs the child's functioning in all life domains as documented by a licensed clinical practitioner

___ Child has a life threatening disease as documented by a medical professional (e.g. brain tumor, cancer, HIV infected- regardless of whether the child is symptomatic at the current time)

___ Child is dependent on life saving equipment (e.g. ventilator dependent, dialysis equipment, oxygen 24 hours a day)

___ Child has a medical/physical condition or impairment that requires an extraordinary level of daily supervision and/or assistance. **Medical professional treating the child must be consulted to determine if child has any of the conditions listed below:** Worker observation will not be considered without documentation from a medical professional.

- 2nd or 3rd degree burns over 10% or more of a child's body.
- Deaf and/or requires the use of adaptive devices and special interventions for hearing and speech.
- Legally blind or vision impairment that results in a handicapping condition in which self-help skills and visual motor skills are delayed.
- Diagnosed with sickle cell anemia disease
- HIV exposed and 18 months or younger
- Type I Juvenile Diabetes
- Diagnosed with hemophilia
- Present day apnea episodes
- Quadriplegic
- Organ transplant
- Diagnosed with muscular dystrophy
- Requires equipment such as wheelchairs
- Diagnosed with spina bifida (which resulted in some disability)
- Partial paralysis (requiring special assistance from persons or devices)
- Moderate to severe respiratory problems requiring nebulization and suctioning 2 to 3 times daily
- Seizure disorder requiring frequent medication, monitoring or ER/hospitalization
- Indwelling catheters or ostomies
- Has gastrostomy tubes (g tubes), jejunostomy tubes (j tubes) and/or trachs
- Diagnosed with Cystic Fibrosis
- Diagnosed with Osteogenesis Imperfecta
- Inborn errors of metabolism that require lifelong specialized diets and follow-up, e.g. Phenylketonuria (PKU)
- Severe heart disease which involves activity limitations and special treatment
- Kidney or liver disease
- Hydrocephalus with shunts
- Major birth defects
- Head and/or facial deformities
- Multiple conditions requiring specialized medical care
- Compromised immune system
- Hormone deficiencies, i.e. lack of growth hormone

Comments: _____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Worker Making Decision to Place the Child Date

_____ _____

Signature of Worker's Supervisor Date

CFS 418-K
07/2002

Department of Children and Family Services

Specialized Foster Care Review Committee Coversheet

Directions: This form must be completed by the caseworker for each child for whom a specialized foster care program is being requested.

Date of Referral: _____

Child Information

Name:_____ ID: _____ DOB:_____ Age: _____

Name of worker: _____ Agency:_____ Region /Site/Field: _____

Phone number: _____ Fax number: _____ Email Address: _____

Supervisor's Name: _____ Phone number: _____

Does this child have a sibling in foster care? ☐ Yes ☐ No

If yes, state the agency(s) responsible for the case management of the sib(s): _____

Does this child have siblings for whom a specialized foster care program is being requested? ☐ Yes ☐ No

Child's Current Setting

☐ Placed with a licensed foster parent
☐ Placed with a licensed relative
☐ Placed with a unlicensed relative
☐ Emergency Shelter
☐ Psychiatric hospitalization or other intensive treatment settings (i.e. substance abuse program)
☐ Hospitalization due to a medical condition
☐ Group home or residential care
☐ Other, specify setting: _____

Anticipated discharge date from above setting, if applicable: _____

Domain(s) of Impairment (check all that apply)

☐ Medical/Physical
☐ Mental Health/Behavioral
☐ Developmentally Disabled

Foster Parent/Relative Caregiver

☐ Current Placement ☐ Previous placement (prior to a temporary or IGH placement)

Name(s): _____

Phone Number(s)	Best Time to Call		Circle Available Days
Work: _____	Beginning: _____am /pm	End:_____am / pm	S, M, T, W, TH, F, S
Home: _____	Beginning: _____am /pm	End:_____am / pm	S, M, T, W, TH, F, S
Other: _____	Beginning: _____am /pm	End:_____am / pm	S, M, T, W, TH, F, S

Mailing Address Street: _____

City: _____ State: _____ Zip: _____

Required Documentation To Be Included

1. The worker's summary of the child's needs, including diagnosis, statement as to why a specialized foster care program is needed, and what additional service(s) the child needs.
2. Child's placement history (printouts of CM-07 are acceptable).
3. Mental Health Certification and/or Medical Certification.
4. Current social history

Child Specific Services

Please indicate which services are currently or have previously been provided to support the child's needs. Additional lines can be added to any type serve listed below in case there is an insufficient amount of space. Pertinent documentation should be attached.

Yes No N/A

1. ☐ ☐ ☐ **Psychological Assessment**

Assessment Date — Type of service and provider

_____ _____

_____ _____

2. ☐ ☐ ☐ **Psychiatric Evaluation**

Assessment Date — Type of service and provider

_____ _____

_____ _____

3. ☐ ☐ ☐ **Counseling /Therapy (including individual, family, group)**

Begin – End date — Type of service and provider — Frequency

_____ - _____ _____ _____

_____ - _____ _____ _____

4. ☐ ☐ ☐ **Mentoring Services**

Begin – End date — Type of service and provider — Frequency

_____ - _____ _____ _____

_____ - _____ _____ _____

5. ☐ ☐ ☐ **Substance Abuse Treatment**

Begin – End date — Type of service and provider — Frequency

_____ - _____ _____ _____

_____ - _____ _____ _____

6. ☐ ☐ ☐ **Respite**

Begin – End date — Type of service and provider — Frequency

_____ - _____ _____ _____

_____ - _____ _____ _____

7. ☐ ☐ ☐ **Medical Assessments/Reports (not including routine medical care)**

Assessment Date — Type of service and provider

_____ _____

_____ _____

8. ☐ ☐ ☐ **Physical therapy**

Begin – End date — Type of service and provider — Frequency

_____ - _____ _____ _____

_____ - _____ _____ _____

9. ☐ ☐ ☐ **Occupational therapy**

Begin – End date — Type of service and provider — Frequency

_____ - _____ _____ _____

_____ - _____ _____ _____

10. ☐ ☐ ☐ **Speech therapy**

Begin – End date	Type of service and provider	Frequency
_____ - _____	_____	_____
_____ - _____	_____	_____

11. ☐ ☐ ☐ **System of Care (SOC)**

Begin – End date	Type of service and provider	Frequency
_____ - _____	_____	_____
_____ - _____	_____	_____

12. ☐ ☐ ☐ **SASS**

Assessment Date	Intervention and provider
_____	_____
_____	_____

13. ☐ ☐ ☐ **SACY services**

Begin – End date	Type of service and provider	Frequency
_____ - _____	_____	_____
_____ - _____	_____	_____

14. ☐ ☐ ☐ **IFSP/IEP (Individual Family Service Plan or Individual Education Plan)**

Assessment Date	Intervention and provider
_____	_____
_____	_____

15. ☐ ☐ ☐ **Tutoring**

Begin – End date	Type of service and provider	Frequency
_____ - _____	_____	_____
_____ - _____	_____	_____

16. ☐ ☐ ☐ **Early Childhood Intervention**

Begin – End date	Type of service and provider	Frequency
_____ - _____	_____	_____
_____ - _____	_____	_____

17. ☐ ☐ ☐ **Recreational/Social Development (i.e. memberships, lessons, etc)**

Begin – End date	Type of service and provider	Frequency
_____ - _____	_____	_____
_____ - _____	_____	_____

18. ☐ ☐ ☐ **Other Service of Therapeutic Intervention (specify):**

Begin – End date	Type of service and provider	Frequency
_____ - _____	_____	_____
_____ - _____	_____	_____

If additional services were accessed, please note the service type and frequency on an attached sheet.

Caseworker Name:_____ **Signature:**_____ **Date:**_____

Supervisor Name:_____ **Signature:**_____ **Date:**_____

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